

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007425

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 36

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAR 4 1963

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		c. CITY OR TOWN <u>Eldridge</u>	
Length of stay in 1b <u>10 Days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Hospital</u>		d. STREET ADDRESS <u>Eldridge</u>	
3. NAME OF DECEASED (Type or print) First <u>Sherman</u> Middle <u>Looney</u> Last <u>Looney</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 3-1892</u>
9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (City and state or country) <u>Camden County Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Looney</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Baker</u>	
14. NAME OF HUSBAND OR WIFE <u>Martha Ellen Looney</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT Address <u>Mrs Katherine Rooffener, Independence Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Acute Extensive Anterior Myocardial Infarction</u> DUE TO (c) <u>Coronary Arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bilateral Hypostatic Pneumonitis.</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>[redacted]</u> a.m. <u>[redacted]</u> p.m. <u>[redacted]</u> Month, Day, Year <u>[redacted]</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1960</u> to <u>1963</u> and last saw him alive on <u>2-26-63</u> Death occurred at <u>11</u> P. M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. J. [redacted] M.D.</u> (Degree or title)		22b. ADDRESS <u>Camden, Mo.</u>	
22c. DATE SIGNED <u>2-28-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Feb. 28-1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Horeb Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Camden County</u>		23e. STATE <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Robert H. Reed</u> ADDRESS <u>Camden Mo.</u>		25. DATE REC'D. BY LOCAL REG. <u>2-28-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Albela L. Hay</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Robert H. Reed

Licensed Embalmer No. 3740

P. O. Address Camdenton Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Permit not sealed - H. K. H.